

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-009007

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED MAR 13 1962

Primary Registration District No. 500 Registrar's No. 737

VS 300
Rev. 4/59

14000

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Lemay</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>Mt. St. Rose Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>6615 Winnebago Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>WALDEMAR</u> Middle <u>H.</u> Last <u>BAUER</u>		4. DATE OF DEATH Month <u>Mar.</u> Day <u>2</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COST ACCOUNTANT</u>		11. BIRTHPLACE (City and state or country) <u>ST LOUIS, MO.</u>	
13a. FATHER'S NAME <u>JOHN BAUER</u>		14. NAME OF HUSBAND OR WIFE <u>Ella Bauer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <u>ELLA BAUER</u> Address <u>ST LOUIS, MO.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Vascular Accident</u> DUE TO (b) <u>Cirrhosis of Liver</u> DUE TO (c) <u>581.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>9:10 A.</u> Month, Day, Year <u>11-25-61</u>		20f. CITY, TOWN, OR LOCATION <u>ST LOUIS</u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21. I attended the deceased from <u>11-25-61</u> to <u>3-2-62</u> and last saw her alive on <u>2-27-62</u>		22c. DATE SIGNED <u>3-2-62</u>	
22a. SIGNATURE <u>Harry A. Reich MD</u> (Degree or title)		22b. ADDRESS <u>5633 S. Kingshighway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>3-5-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		23d. LOCATION (City, town, or county) <u>ST LOUIS</u>	
24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u>		25. DATE RECD. BY LOCAL REG. <u>3-2-62</u>	
26. REGISTRAR'S SIGNATURE <u>John B. Murphy MD</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

William B. White

Licensed Embalmer No. *4291*

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.